Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
PETER EDWARD GRAYS

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-11-1812-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
February 1, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Multiple procedure discount should not apply"

Amount in Dispute: $569.64

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual maintains its position the lipoma removal is a secondary procedure to the hernia repair. As such it is subject to the CCI Edits notwithstanding the -59 modifier."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Highway 290, Austin, Texas 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 9, 2010	Procedure code 55520	$569.64	$182.63

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
3. 28 Texas Administrative Code §133.4 requires written notification to health care providers regarding contractual agreements for informal and voluntary networks.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - B5 – COVERAGE/PROGRAM GUIDELINES WERE NOT MET OR WERE EXCEEDED.
   - 59 – PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES. (FOR EXAMPLE MULTIPLE SURGERY OR DIAGNOSTIC IMAGING, CONCURRENT ANESTHESIA.)
   - 131 – CLAIM SPECIFIC NEGOTIATED DISCOUNT.

- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 329 – ALLOWANCE FOR THIS SERVICE REPRESENTS 50% BECAUSE OF MULTIPLE OR BILATERAL RULES.
- 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824
- 729 –THIS BILL WAS REVIEWED IN ACCORDANCE WITH YOUR FIRST HEALTH CONTRACT. FOR QUESTIONS PLEASE CALL 1-800-937-6824
- 757 – NETWORK REDUCTIONS BASED ON FOCUS HEALTHCARE CONTRACT. FOR QUESTIONS REGARDING NETWORK REDUCTIONS CALL 1-800-243-2336

Issues

1. Are the disputed services subject to a claim specific negotiated discount?
2. Are the disputed services subject to a contract between the parties to this dispute?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced payment for disputed services with reason code 131 – "CLAIM SPECIFIC NEGOTIATED DISCOUNT." 28 Texas Administrative Code §134.203(g) requires that "When there is a negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the negotiated or contracted amount that applies to the billed services." No documentation was presented to support a claim specific negotiated discount; therefore, the Division finds that no claim specific negotiated discount applies to the billed services.
2. The insurance carrier reduced payment for disputed services with reason codes 729 –"THIS BILL WAS REVIEWED IN ACCORDANCE WITH YOUR FIRST HEALTH CONTRACT. FOR QUESTIONS PLEASE CALL 1-800-937-6824"; and 757 – "NETWORK REDUCTIONS BASED ON FOCUS HEALTHCARE CONTRACT. FOR QUESTIONS REGARDING NETWORK REDUCTIONS CALL 1-800-243-2336." Review of the submitted information found insufficient documentation to support that the disputed services are subject to a contract. Nevertheless, on March 15, 2011, the Division requested the respondent to provide documentation to support the contractual payment reduction in accordance with Labor Code Sec. 413.011(d-3) and (d-1)(2), as well as documentation to support notification to the health care provider in accordance with 28 Texas Administrative Code §133.4.

   Labor Code Sec. 413.011(d-1) requires that:

   > If a carrier or the carrier's authorized agent chooses to use an informal or voluntary network to obtain a contractual fee arrangement, there must be a contractual arrangement between:
   >
   > (1) the carrier or authorized agent and the informal or voluntary network that authorizes the network to contract with health care providers on the carrier's behalf; and
   >
   > (2) the informal or voluntary network and the health care provider that includes a specific fee schedule and complies with the notice requirements established under Subsection (d-2).

   Labor Code Sec. 413.011(d-2) requires that

   > "An informal or voluntary network, or the carrier or the carrier's authorized agent, as appropriate, shall notify each health care provider of any person that is given access to the network's fee arrangements with that health care provider within the time and according to the manner provided by commissioner rule."

   Labor Code Sec. 413.011(d-3) states, in pertinent part, that:

   > An insurance carrier shall provide copies of each contract described by Subsection (d-1) to the division on the request of the division. . . . Notwithstanding Subsection (d-1) or Section 1305.153, Insurance Code, the insurance carrier may be required to pay fees in accordance with the division's fee guidelines if the contract: . . .
   >
   > (3) does not:
   >
   > (A) clearly state that the contractual fee arrangement is between the health care provider and the named insurance carrier or the named insurance carrier's authorized agent; or
   >
   > (B) comply with the notice requirements under Subsection (d-2).

28 Texas Administrative Code §133.4(c) further requires that:

> Required Notice. Each informal network or voluntary network, or the insurance carrier, or the insurance carrier's authorized agent, as appropriate, shall notify each affected health care provider of any person that is given access to the informal or voluntary network's fee arrangement with that health care provider within the time and manner provided by this section.

28 Texas Administrative Code §133.4(g) states that:

> The insurance carrier is not entitled to pay a health care provider at a contracted fee negotiated by an informal network or voluntary network if:
>
> (1) the notice to the health care provider does not meet the requirements of Labor Code §413.011 and this section; or
>
> (2) there are no required contracts in accordance with Labor Code §413.011(d-1) and §413.0115.

Review of the submitted information finds that:

- No documentation was submitted to support a contractual arrangement between the carrier or authorized agent and the alleged informal or voluntary network that authorizes the network to contract with health care providers on the carrier's (Texas Mutual's) behalf in accordance with Subsection (d-1)(1).
- No documentation was found to support notice to the health care provider that Texas Mutual had been given access to the network's fee arrangements with the health care provider in accordance with Labor Code 413.011(d), Subsections (d-2), (d-1)(2), and (d-3)(3)(B), or 28 Texas Administrative Code §133.4.
- No documentation was found to clearly state that the contractual fee arrangement is between the health care provider and the named insurance carrier (Texas Mutual) or the named insurance carrier's authorized agent in accordance with Subsection (d-3)(3)(A)

The Division therefore finds that the insurance carrier's payment reduction reason is not supported. Consequently, the Division concludes that the insurance carrier is not entitled to pay the health care provider at a contracted fee negotiated by an informal network or voluntary network and may not pay fees that are inconsistent with the Division's fee guidelines. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.

3. This dispute relates to professional medical services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.203(c), which requires that "To determine the MAR [Maximum Allowable Reimbursement] for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year." The applicable Division conversion factor for surgery performed in a facility setting for calendar year 2010 is $68.19. Reimbursement is calculated as follows:

   - Procedure code 55520, service date August 24, 2010, performed in Fort Worth, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 6.66 multiplied by the geographic practice cost index (GPCI) for work of 1 is 6.66. The practice expense (PE) RVU of 4.01 multiplied by the PE GPCI of 0.977 is 3.91777. The malpractice RVU of 1 multiplied by the malpractice GPCI of 1.11 is 1.11. The sum of 11.6878 is multiplied by the Division conversion factor of $68.47 for a reimbursement of $800.26. This service has a multiple surgery payment policy indicator of 2, which, per Medicare payment policy, indicates that standard payment adjustment rules for multiple procedures apply. If the procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, highest paying procedure is paid at 100%; all others are paid at 50%. Payment is based on the lower of (a) the actual charge, or (b) the fee schedule amount reduced by the appropriate percentage. This procedure was performed in conjunction with procedure code 49507, which also has a multiple surgery payment policy indicator of 2. Of the two, procedure code 49507 is the highest paying procedure; therefore, the fee schedule amount for the secondary procedure code 55520 is reduced by 50%. The provider billed this service with modifier code -59. Modifier -59 is used to distinguish separate services for which payment would otherwise be included in the charge for another procedure when a Correct Coding Initiative (CCI) edit applies. However, no CCI edits were indicated for nor applied to the services in this dispute. Modifier -59 is used to override CCI edits where circumstances support separate payment of the additional services. Modifier -59 does not apply to the multiple surgery payment reduction. Medicare payment policy still requires the multiple surgery payment reduction to be applied to additional surgeries performed on the same date, regardless of

the use of any modifier. The respondent asserts that "the lipoma removal is a secondary procedure to the hernia repair. As such it is subject to the CCI Edits notwithstanding the -59 modifier." This statement is incorrect. As stated above, no CCI Edit applies to this code pair, and therefore no reduction is being applied to the payment on the basis of a CCI edit. The payment reduction is due to a separate Medicare payment policy based on the multiple surgery payment reduction rules—which are not subject to exceptions, despite the provider's use of modifier -59. Accordingly, as the secondary surgery performed on the same date, payment for procedure code 55520 is reduced by 50%. $800.26 multiplied by 50% yields a MAR of $400.13.

4. The total recommended payment for the services in dispute is $400.13. This amount less the amount previously paid by the insurance carrier of $217.50 leaves an amount due to the requestor of $182.63. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $182.63.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $182.63 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	October 17, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.